DOCUMENT RESUME

ED 104 088 EC 071 949

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TITLE Group Counseling with the Mentally Retarded: A Set of Guidelines for Practice. Working Paper No. 77.
INSTITUTION Oregon Univ., Eugene. Rehabilitation Research and Training Center in Mental Retardation.
PUB DATE Jun 74
NOTE 26p.

EDRS PRICE MF-$0.76 HC-$1.95 PLUS POSTAGE
DESCRIPTORS Counseling; Emotional Problems; Exceptional Child Services; Group Dynamics; Group Structure; *Group Therapy; *Guidelines; *Mentally Handicapped; *Success Factors

ABSTRACT

Presented are guidelines for developing and conducting a group counseling program with the mentally retarded. Advantages of the group counseling approach (such as peer influence), goals for the group (such as teaching skills), and characteristics of an effective group leader (such as empathetic understanding) are outlined. Factors related to group composition (such as the value of including persons of similar intelligence), and various procedures (such as directive vs. nondirective) are considered. Also pointed out are general trends related to group dynamics (such as that early sessions are often chaotic). The major portion of the document describes special techniques useful with aggressive clients during the warming-up phase of counseling (including Indian hand wrestling and the silent insult technique), and other appropriate techniques (such as a courtroom scene and psychodrama). (LS)

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WORKING PAPER NO. 77

GROUP COUNSELING WITH THE MENTALLY RETARDED: A SET OF GUIDELINES FOR PRACTICE

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June 1974

Group Counseling with the Mentally Retarded: A Set of Guidelines for Practice

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Traditionally, the mentally retarded have been regarded as poor candidates for counseling and psychotherapy primarily due to their level of intellectual functioning. This attitude is still prevalent in spite of the fact that persons with mental retardation can profit from many forms of psychotherapeutic intervention. One of the more promising methods in working with this client population is group counseling.

The purpose of this paper is to present a set of guidelines for developing and conducting a group counseling program with the mentally retarded. Specifically, attention is directed to (1) advantages, (2) goals, (3) group leader, (4) group characteristics, (5) procedures, (6) dynamics, and (7) special techniques. General guidelines are presented for each section and should serve as a framework for the practitioner interested in implementing a group counseling program with this client population. These guidelines should not be considered as rigid formulations since the material discussed is based on the premise that each group is unique, and methods must be individually tailored to the needs of the particular group.

Advantages

Guideline No. 1. Four of the major advantages of group vs. individual counseling are: (1) economics; (2) effectiveness for improving adaptive and social skills; (3) influence of peers in addition to counselor's input; and (4) a diagnostic tool for observing members in social situations.

A review of the literature on counseling approaches with the mentally retarded revealed that the majority was related to the group approach (Sternlicht, 1966a). Group counseling is most economical in terms of time and money since one counselor can serve several clients in an hour as opposed to the single individual in the one-to-one relationship. This method is particularly useful in schools and residential facilities where funds and trained personnel are at a premium (Sternlicht & Wanderer, 1963).

Impairment in adaptive behavior is generally considered to be the primary deficit of the mentally retarded (Halpern & Berard, 1972). The group approach is most appropriate for enhancing the client's social adaptation since the group itself is a social milieu. In addition, it provides a medium for making choices which approximate those made in the outside world.

The influence of peers in a constructive group setting is another important advantage. For example, a group experience where a member gains acceptance by a number of his peers is more potent than being accepted by an individual counselor. Members of the group can also observe the problems of others. The individual realizes that others have similar problems, fears, or guilts and that one is not unique in his feelings.

A major problem of the mentally retarded is the label and stigma that society has placed on them. The group provides an atmosphere where individuals sensitive to the label may share such feelings and learn alternative ways of coping with the problem. In the process, the group members learn how to give and receive emotional support from each other. Improvements on measures of self-concept and personality ratings were demonstrated for mentally retarded persons receiving group counseling by Humes (1968), Mann, Beaber and Jackson (1969), and Rosen and Rosen (1969).

Finally, with group counseling the client's psychodynamics can be observed in a real-life social situation. The group experience may be used in this manner as a unique diagnostic tool by the group leader. Selwa (1971) notes that insights gained in group counseling sessions can be used for making recommendations to teachers and principals concerning the most effective ways to deal with mentally retarded students. Specifically, group members needing a more intensive individualized approach may then be referred for such intervention after appropriate observations are made in the group.

Goals

> Guideline No. 2. Goals for group counseling programs must be individually tailored depending upon the needs of the particular group. A group counseling program for the mentally retarded may have two or three simultaneous goals. The usual primary goal is to develop or produce growth in the participants. Secondary goals such as teaching a skill or accomplishing a project may be incorporated in the program.

There is no universal specific goal applicable to all counseling groups. Group counseling is performed under a myriad of conditions ranging from public schools, to sheltered workshops, to residential wards in large institutions. Moreover, each group is composed of unique individuals bringing with them different life histories, value systems, and personalities. Thus, the group leader must individualize his goals as well as techniques to accommodate the demands of the particular situation.

In spite of the fact that there are no universal goals, some attempt has been made to classify the purposes of groups. The following represents one classification of group goals: (1) to teach skills, (2) to accomplish a project, or (3) to develop or produce personal growth in the participants.

Skills-centered groups are intended to provide a structured learning situation. Classrooms and other learning environments are examples of group settings where specific skills are taught to participants. Project-centered groups attempt to produce a tangible product. Examples include assembling components in a workshop or the production of a class play. Growth-centered or developmental groups are aimed at some alteration of the member's self-perception or behavior such as the acquisition of improved social skills, personal feedback, or insight. This latter set of goals are those associated with group counseling (Glanz, 1962).

Gazda, Duncan and Meadows (1967) define the purpose of group counseling as follows:

> Group counseling is a dynamic interpersonal process focusing on conscious thought and behavior and involving the therapy functions of permissiveness, orientation to reality, catharsis, and mutual trust, caring, understanding, acceptance and support. The therapy functions are created and nurtured in a small group through the sharing of personal concerns with one's peers and the counselor(s).... The group counselee may utilize the group interaction to increase understanding and acceptance of values and goals and to learn and/or unlearn certain attitudes and behaviors [p. 305].

Although counseling groups by tradition have been developmental or growth centered in goals, such a position frequently is not feasible or even necessarily the most productive in working with the mentally retarded. It is often more expedient to supplement a primary growth-centered goal with a skill- or project-centered one in forming a counseling group for this population. For example, a class play can be produced by members of a counseling group to teach new ways of behaving in social situations. In essence, the goals for each group must be individualized for the unique setting and persons involved.

The Group Leader

Guideline No. 3. The group leader should possess: (1) the basic facilitative core essential for all counselors; and (2) have some knowledge of the social-psychological parameters of mental retardation.

The required qualifications for a person leading a counseling group is a topic of frequent debate. The emphasis of this section is on the basic skills required of a group leader rather than the particular route for obtaining such training. Group counseling is the term mainly used in this paper although a differentiation between group psychotherapy and group counseling is not made. The author is of the opinion that differentiations between the two terms are rather arbitrary.

The basic core characteristics of the counselor which are necessary, although not totally sufficient by themselves, to produce therapeutic personality change were first expressed by Rogers (1957). These core characteristics were later elaborated upon by Truax and Carkhuff (1964) and later refined by Carkhuff (1969a; 1969b). It is generally agreed upon that the elucidation of this "facilitative core" has been a major contribution to counseling and psychotherapy, and may be considered as a necessary pre-requisite for personality change regardless of the theoretical orientation of the counselor or psychotherapist.

The basic core characteristics are: (1) empathetic understanding or accurate empathy, (2) unconditional positive regard or nonpossessive warmth, and (3) self-congruence or genuineness. Accurate empathy refers to the ability of the counselor to correctly understand, accept and empathize with the client's feelings. Nonpossessive warmth refers to the counselor's consideration and respect for the client as a unique person and is manifested in the counselor by being sensitive, friendly, and responsive. Genuineness

might be viewed as the counselor being honest, sincere, and "straightforward" in his attitudes toward the client(s).

The successful group leader should also possess a body of knowledge about mental retardation. Moreover, it is important that the leader be free of stereotypes often associated with such persons. An understanding of the social-psychological parameters is important as well as a knowledge of the problems faced by these persons as students, family members, peer group members, and workers (Halpern and Berard, 1974).

Group Characteristics

> Guideline No. 4. A major factor determining success in counseling groups of the mentally retarded is the composition of the group. Group counseling generally is most appropriate for persons in the upper portion of the mentally retarded range. Other considerations pertaining to the composition include: (1) similarity of background, age, and intellectual level; (2) a mixture of behavioral types; (3) a limited number of group participants; and (4) length and duration of sessions.

Group counseling is most appropriate for those persons in the upper portion of the mentally retarded range usually designated as "educable," "cultural-familial," or "mildly retarded." Generally, the mildly retarded person is noninstitutionalized and lives in the community following the termination of his attendance in school although some are placed in institutions when family difficulties exist. Sternlicht (1966a) reviewed over 50 journal articles in the field of group counseling with the mentally retarded. He reported that none of the studies dealing with a noninstitutionalized population reported any failures and hypothesized the importance of the home and family on a favorable therapeutic prognosis.

Little can be done for a group either through activities or therapist intervention when the composition is faulty. It is most advantageous to

include persons of similar background, age, and intelligence range. Homogeneity on these variables will increase the chances of group interaction and identification with the problems of the other members in the group.

In terms of the behavioral composition, however, a mixture of behavior problems operate most therapeutically (Fisher, 1953; Astrachan, 1955). More specifically, the more aggressive youngsters facilitate the expression of emotions on the submissive members, and the more inhibited members act as a controlling factor on the hostility of the more aggressive ones. Wilcox and Guthrie (1957) demonstrated the importance of a behavioral balance. Ninety-seven mentally retarded females were divided into three groups: one aggressive, one passive, and one mixed group. The mixed group containing both passive and aggressive members provided the best therapeutic outcomes.

A group leader must keep in mind that the larger a group becomes the more difficult it is to relate to each individual in the group. A group of mentally retarded individuals generally should not consist of more than eight persons. The more antisocial the attitudes of the group members, the fewer are the number of clients that can be handled. A group of eight is frequently too large when one is counseling with aggressive members (Combs, et al., 1963). Cotzin (1948) points out that no more than five retarded clients should be included in any one counseling group for the most effective therapy. Moreover, he states that three children who are seriously disturbed in relationships to adults or other children is the maximum number that can be handled in a group.

Time and length of the group meetings are two important characteristics to consider in implementing a group counseling program. Groups should meet

for a minimum of a 1-hour session per week. The most successful groups with the mentally retarded generally meet for at least a 6-month duration (Sternlicht, 1966a).

Procedures

> Guideline No. 5. Group counseling approaches with the mentally retarded must be individualized with an emphasis on the needs of the specific group. A directive framework is more effective than a nondirective one although the group leader might choose to use nondirective techniques when appropriate. The incorporation of nonverbal techniques is particularly important when working with mentally retarded individuals.

The specific procedures used in a group are dependent upon the composition of the group members and the goals. Chess (1962) investigated 19 subjects and determined that for successful counseling to take place, the goals and procedures had to be individualized with an emphasis on diagnostic information. Group leaders must be aware of a variety of verbal and nonverbal procedures when conducting groups of the mentally retarded.

The controversy over directive vs. nondirective approaches has been a long-standing issue in group counseling. The majority of the research reviewed by Sternlicht (1966a) favors the directive approach for group counseling with the mentally retarded. Vail (1955) reported on a pilot study using a nondirective method with mentally retarded boys. No fundamental changes in psychological structure, dynamics, or emotional problems were found. It was concluded by the investigator that the nondirective therapeutic method was at fault because of the emphasis on verbal communication and insight. Wilcox and Guthrie (1957) also found a lack of progress in group counseling when a nondirective approach was employed; after the approach became more directive, the counseling became more productive. The role of the counselor included taking the lead in bringing up topics, holding the

group to a particular topic, and encouraging participation by all members. They concluded that directive therapy was most effective in producing change.

Bevan (1960) emphasized the techniques of clarification and reflection of attitudes as most effective when nondirective approaches are being used. Snyder and Secrest (1959) stated that the role of the counselor should be one of a guiding, manipulating leader, interacting minimally but who is willing to structure and organize the sessions when required. This method utilized concrete materials in an atmosphere of permissiveness within a directive framework. Stuberline (1957) related that time spent with mentally retarded clients by sympathetic, noncritical, and supportive adults is valuable in itself.

Tavris (1961) stressed the importance of the use of nonverbal communication aspects of the counseling process. He found the client's verbal insights of only limited value because of language deficits, and it was suggested that attitudes were transmitted on a nonlanguage basis.

Wanderer and Sternlicht (1964) used a modified directive approach to avoid overdependency upon the counselor by the client. The approach emphasized a discussion of behavioral alternatives in the group. In this manner, the directive approach to counseling the mentally retarded was used, but in offering the clients choices, the final decisions were made by them.

Hortmuth (1965) stated the position that a group counseling program must incorporate a school, training, recreation or work program to be effective. The author's therapy program consisted of group sessions concerning such issues as problems with parents and feelings of limitation regarding dating or sex. The point was made that a therapy program without a framework of meeting an individual's needs had little value.

Similarly, Gootzeit, Lombardo, and Milner (1960) used situational therapy. In this procedure, the client is observed in the environment and the observer makes notes on such behaviors as hostility, aggressiveness, daydreaming, and the like. From the observations recorded, procedures are developed for manipulating the environment. Although this method might not be regarded as group counseling in the traditional sense, the authors viewed the procedures as a form of group therapy in which the patient participates without being aware. Indeed, such a method can be used simultaneously with more traditional group counseling approaches.

Group Dynamics

> Guideline No. 6. General trends may be discerned when comparing groups of the mentally retarded although each group is unique depending upon the interaction of the leader and clients selected. The following three stages are not uncommon in the group counseling process: (1) early sessions are often fragmented and chaotic; (2) later sessions frequently involve the discovery of common problems and difficulties; and (3) final sessions are often reflected by group cohesiveness.

Every group is unique depending upon the personality of the leader and the interaction of the particular participants. On the other hand, there are some general trends or patterns that tend to manifest themselves in counseling groups of the mentally retarded. This section reviews the classification categories as formulated by two separate investigators.

Kaufman (1963) reports on several phases in group counseling used to prepare long-term residents of an institution for the mentally retarded for community life. The initial phase (first few sessions) was quite chaotic. The discussions were egocentric, and there was disregard for what others were saying with all comments being directed to the therapist.

In order to deal with the chaotic state of affairs, the leader decided that additional structure was required. First, a rule was established to allow each person to finish what he was saying before the subject was changed. Second, each individual was asked in the beginning of the session which topics or problems he wanted to have included in the discussion. With the passing of time, the group began asking more relevant questions such as: "Why am I called mental defective?" and "Someone asked me where I was from, and I didn't know if I should tell him I was from the institution."

Later on in the group therapy, a number of changes took place. Members demonstrated a greater capacity to recognize the existence of common difficulties. There was less shifting from topic to topic as in the initial phase. The author also reported more respect for the rights of other group members and an increased tolerance of differences of opinion. Four aspects of group process were observed: (1) the transference of long-held attitudes regarding significant others toward the therapist; (2) catharsis or ventilation of feelings; (3) social pressure of the group toward conformity in such areas as dress, chronic lateness or immature behavior toward members of the opposite sex; and (4) new impetus for learning. This included both an increased motivation to pursue educational experiences such as night school and the tendency to become more self-reflective, especially in regard to generalizing from the group experience and adopting new ways of coping with problems.

Fisher and Wolfson (1953) classified two institutional therapy groups, each consisting of 36 sessions, into six phases of approximately 6 sessions each. Phase One: This was a period where the members tested to see how permissive the leader would be. Phase Two: This was classified as the

regressive period. Since this group incorporated play therapy, the furnishing of food to the group fostered the expression of regressive tendencies. Phase Three: Period of transition from "ego-centeredness" to "group-centeredness." Even though members frequently criticized one or more individuals of the group there was little hostility displayed in the expression of criticism. Phase Four: Stage of positive sibling transference. In this stage, the group members expressed generally positive emotions toward the leader. Phase Five: Concern about each other's welfare in the group. Taboo subjects such as "babies" and other sexual topics were brought into the open. Phase Six: Discussion of proper behavior, religion, and areas even further removed from the personal world.

Special Techniques

> Guideline No. 7. A working knowledge of specialized techniques is essential for leading counseling groups of the mentally retarded. During the initial or warming-up phase, Indian hand wrestling, fighting under controlled conditions, and the silent insult technique, are particularly useful with aggressive youngsters. The methods of "courtroom scene" and psychodrama have also proved to be especially effective when used in group counseling programs.

A working knowledge of a variety of techniques should be incorporated by group leaders to facilitate specific problems and issues within groups. Programmed or planned use of techniques frequently are doomed to failure because of the inappropriate use of the technique at a particular time. The ability to select an appropriate technique during a specific impasse is the most facilitative use of such methods. The first three procedures to be reviewed are most useful with aggressive clients during the initial or warming-up phase of group counseling, while the rest may be used during warming-up or later stages.

Indian hand wrestling. Sternlicht (1965a) discussed the problem of establishing the initial relationship with a group of institutionalized, delinquent mentally retarded adolescents. These youngsters all had educational retardation and poor verbal facility in common. All of the clients had behavior problems and demonstrated severe destructive and aggressive behavior. The major problem in conducting group counseling was the inability to control the rampant acting-out within the therapy room.

Rapport was established by asking the group for its strongest member. Fighting matches were then conducted between individuals who thought they were the strongest. The peer group watched to determine that the fighting was clean and the therapist served as a referee, and terminated the matches before any physical damage occurred.

The strongest boy in the group was subsequently selected, and he had to Indian hand wrestle with the therapist. Two factors insured that the therapist always won the battle. First, the opponent was fatigued due to his previous matches with the other members. Second, the therapist used leverage by making sure that his arm was on a higher level than the patient's. The therapist's success impressed the group and resulted in the establishment of a working relationship with the members. The therapist was then able to assume a permissive role and encouraged individual expression within structured boundaries and a minimum of rules.

The more manipulative techniques such as Indian hand wrestling should be used sparingly since manipulation is contrary to the goal of developing personal growth. However, such methods might be required for an extremely aggressive group in order to help achieve a growth-centered goal during later sessions.

Fighting under controlled conditions. Cotzin (1948) conducted group psychotherapy with mentally retarded problem boys. The entire first session was chaotic with each youngster becoming aggressive, hostile and bitter toward the therapist and the other members of the group. A method was devised to allow members to fight under controlled conditions. The members were paired off according to mutual hostility and consent. The therapist acted as the impartial referee and several boxing rounds were fought. The other members acted as an audience and the bouts were terminated by mutual consent of the participants. The author reported that this technique was found to be a most successful way of channeling aggressive energy of the youngsters and to bring the group to a relatively undisturbed status.

Silent insult technique. The silent insult technique was employed by Sternlicht (1966b) to help establish therapeutic process during early sessions. In this method, the leader said nothing during the first session. The members demonstrated loud and boisterous activity but finally quieted down and began to question the leader about his silence. The group leader related that he did not like their aggressive behavior and the silence was his way of insulting them. This resulted in numerous verbal replies from the group, and facilitated the group process.

Other warm-up techniques. Less aggressive groups can use other techniques in the warming-up phase. These include: (1) activity therapy--each youngster can build an airplane, work with clay, or do some other type of arts and crafts project; (2) storytelling or psychodrama--each youngster in the group can tell a personal vignette from his life or can participate in a psychodrama as discussed in a later section; or (3) each youngster, in turn, can serve as the group leader's assistant during a session (Cotzin, 1948).

Courtroom scene. Cotzin (1948) used a method entitled "courtroom scene." In this procedure, the therapist served as judge, and each youngster, in turn, as the defendant on the stand and as prosecutor; the rest of the youngsters served as the jury. After a youngster had been selected for defendant, the prosecutor stated what he knew about him. The prosecutor could say anything about the defendant and no coaching was used. The defendant was required to wait until the prosecutor was finished and then had the opportunity to defend himself. The remaining youngsters, as jury members, listened to the testimony of the prosecutor and the defendant.

The author reported that this method took some time to run smoothly. In the end, the youngsters appeared to be obtaining insights about themselves from the remarks which were made about them. Moreover, diagnosis by the therapist was made easier and the dynamics of each youngster was revealed.

Psychodrama-sociodrama. Sociodrama was introduced by Moreno in 1944, and it is an unrehearsed spontaneous presentation by the group members. Blackhurst (1966) defines sociodrama as "the acting out of social situations with individuals assuming the roles of the participants involved [p. 136]." Advantages of sociodrama were viewed as: (1) acting out, rather than discussion, of problems of social interaction; (2) insight into varieties of means of dealing interpersonally; (3) practice in social skills, and (4) observation and discussions which contribute to general understanding of human behavior. The sociodrama consists of three parts: (1) the warm up, (2) the sociodrama itself, and (3) the discussion. A real incidence or occurrence common in the experience of the group members is used for the subject matter, while the purpose is to release tensions and gain insight.

Psychodrama is a particularly useful technique with the mentally retarded since it is a form of cathartic therapy for which normal verbal activity is not essential (Sternlicht, 1965b). Although some authors make a distinction between psychodrama, sociodrama, and role playing, the terms will be used interchangeably for the purposes of this section. Pankratz (1965), Lavalli and Levine (1954), and Arnholter (1955), present some practical procedures for psychodrama with the mentally retarded.

Arnholter (1955) states that retarded adolescents, especially those for whom interpersonal relationships have been difficult, may be reluctant to enter into psychodrama. A warm-up procedure is particularly important for these retarded adolescents; the paper bag technique is related by the author. In this method, faces are drawn with crayon on paper bags which can be mounted on sticks or slipped over the hands of teenagers as hand-puppets. When roles are selected, the teenager who is to portray "papa," for example, holds the face with the moustache. After the sociodrama is in progress, the paper bag faces may be laid aside, having served their purposes.

Roles should be assigned by choice of the participants after the leader indicates that a drama is to be presented in which the members try to find answers to a common problem. The drama can be selected from virtually any subject matter common to the group and can serve as a practical learning experience to acquire acceptable attitudes and social skills. Lavalli and Levine (1954) list several examples of sociodramas.

1. A sociodrama of "troubles." No roles are assigned. Each youngster contributes to the discussion spontaneously [p. 545].
2. In this sociodrama one boy is expected to take the role of the father. Two other boys are the sons who come in at midnight [p. 547].

3. In a sociodrama on "finances" the girls pretend that they are having a soda together after school and talking over some of their problems about money [p. 548].
4. A sociodrama where boys pretend to be fathers [p. 548].
5. Two boys discuss what they plan to do with their first pay checks [p. 549].
6. In a sociodrama on "dating" no roles are assigned and in most instances the boy friends and the situations are imaginative [p. 549].
7. The boys discuss "choosing a marriage partner" in this sociodrama [p. 551].

Other techniques. A number of nonverbal techniques for use with groups of mentally retarded individuals were reviewed by Sternlicht (1966b). Pantomime was found to be effective when acted out by the group leader alone or with one volunteer. Full-length and hand mirrors were used to give feedback to group members concerning how their actions appeared to others.

Balloons were used in groups for various purposes. One procedure in which each member blew up and destroyed balloons was utilized to demonstrate such personality dynamics as degree of aggressiveness, need for structure and testing the limits. Also, the balloons were used to teach creative skills when the group morale was low. Animals and other objects were created by the group members and this skill was relatively easy to teach to the group.

In summary, the group leader in working with the mentally retarded must be prepared to use specialized techniques which include nonverbal and

activity-oriented approaches. Indian hand wrestling, fighting under controlled conditions, and the silent insult technique are particularly useful with aggressive youngsters. During later sessions, such techniques as "courtroom scene" and psychodrama-sociodrama procedures are appropriate.

Summary and Conclusions

The primary purpose of this paper was to present a set of practical guidelines for conducting a group counseling program with the mentally retarded in a concise, sequential format. Guidelines for leading a counseling group with these persons were organized into seven areas: (1) Advantages of the group counseling approach; (2) Goals for the group; (3) Characteristics of an effective group leader; (4) Selection of group members and characteristics of the group; (5) Procedures in group counseling; (6) Group dynamics; and (7) Special techniques.

Group counseling with the mentally retarded is a therapeutic modality of demonstrated value. The group leader, however, must use a flexible approach and have at his disposal an array of techniques and procedures useful for specific situations. Like therapy with nonretarded groups, no one approach has universal advantages over the others. Generally speaking, directive and nonverbal approaches appear to be most promising, especially with those of lesser verbal ability. In the final analysis, the decision to use a particular technique must be made by utilizing clinical judgment based on the dynamics and goals of the group.

The techniques useful for counseling groups of the mentally retarded are expanding. The group leader would be wise to review the literature periodically in order to gain acquaintance with new procedures and to report any innovations he has found to be useful. A comprehensive theoretical model

for group counseling with the mentally retarded appears to be a long way off. For the present, concentration on the most useful techniques and procedures seems to be most productive.

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